CMS GUIDANCE ON THE ACTUARIAL EQUIVALENCE STANDARD FOR THE RETIREE DRUG SUBSIDY
April 7, 2005

Introduction

Subpart R of the Title I Medicare Modernization Act (MMA) Final Rule, published in the January 28, 2005 *Federal Register*, implements §1860D-22 of the Social Security Act, which authorizes subsidy payments to the sponsor of a qualified retiree prescription drug plan. Among the qualification requirements is that a qualified actuary submit an attestation to CMS that the plan's actuarial value is at least equal to the actuarial value of defined standard prescription drug coverage under Part D of Medicare. The final rule defines the actuarial equivalence standard, requires that an attestation be based on generally accepted actuarial principles, and states some specific rules on how to apply the attestation in various situations. This guidance is intended to further clarify several issues relating to the methodology for actuarial equivalence attestations and to make it less burdensome for actuaries to complete the actuarial attestation.

Of all the options available for employers and unions under the MMA, the retiree drug subsidy provides the most continuity for existing retiree prescription drug plans. It is the least burdensome option to administer and provides the most design flexibility as long as the sponsor's plan is at least actuarially equivalent to the defined standard prescription drug benefit under Part D. See the Retiree Drug Subsidy: Why Employers and Union Plan Sponsors Should Consider It, April 6, 2005, paper outlining the 5 easy steps to apply for the retiree drug subsidy.

Background

The standard for actuarial equivalence in Subpart R is a two-prong test in which the sponsor's retiree prescription drug program must provide coverage to its Medicare beneficiaries the value of which is at least equal to the value of the coverage the same beneficiaries would receive under the defined standard prescription drug coverage. The first prong is the "gross value" test in which the expected amount of paid claims for Medicare beneficiaries under the sponsor's plan must be at least equal to the expected amount of paid claims for the same beneficiaries under the defined standard prescription drug coverage, including catastrophic coverage available when an individual's out-of-pocket expenses exceed a specified threshold ($3,600 in 2006). See 42 CFR §423.884(d)(1)(i).

The second prong is the "net value" test in which the net value of the sponsor's plan must be at least equal to the net value of the defined standard prescription drug coverage. See §423.884(d)(1)(ii). The net value of the sponsor's plan is calculated by subtracting the retiree premium/contribution from the gross value of the sponsor's plan. See §423.884(d)(5)(ii)(B)(1). The net value of defined standard prescription drug coverage

under Part D is calculated by subtracting the prescribed national beneficiary premium from the gross value of the defined standard prescription drug coverage.

For those sponsors that plan to supplement the coverage provided under Part D for their retirees that choose Part D, an additional adjustment to the net value of Part D is permitted that accounts for the impact that the sponsor's supplemental coverage will have on the value of defined standard prescription drug coverage under Part D. See §423.884(d)(5)(ii)(B)(2). By delaying the point at which the individual receives catastrophic coverage under Part D, the supplemental coverage will lower the value of defined standard prescription drug coverage to their plan participants. This anticipated reduction in the value of the defined standard prescription drug coverage under Medicare Part D plan to the plan's retirees resulting from supplemental plan will be referred to in this guidance as the "Medicare Supplemental Adjustment" value.

Clarifications to the Regulation

Premiums

Pursuant to §423.884(d)(5)(iii)(B)(1), in calculating the net value of the defined standard prescription drug coverage under Part D for purposes of the second prong of the actuarial equivalence test, the beneficiary premium is subtracted from the gross value of Part D. This guidance clarifies that the national average beneficiary premium can be used to determine the beneficiary premium for this purpose. One should use the national average beneficiary premium for the same year from which the Part D coverage limits are being utilized for the test. Alternatively, the beneficiary premium can be determined by multiplying the gross value of Part D by 25.5%. In either case, there is no requirement to account for beneficiaries in the plan who may be eligible for reduced premiums (or enhanced benefits) through the low-income subsidy provisions of Subpart P of the final rule (§423.771 et. seq.).

Calculating the Value of Drug Coverage under the Sponsor's Plan

In calculating the gross value of the sponsor's plan under §423.884(d)(1)(i), this guidance clarifies that only prescription drugs that are Part D drugs as defined in §423.882 can be considered; however, the drugs do not necessarily have to be in any Part D plan's formulary to be included in the calculation. Generally, Part D drugs are prescription drugs that are not covered by Part A or Part B of Medicare and may not be excluded from coverage under §1860D-2(e)(2)(A) of the Social Security Act. See the discussion of the definition of "Gross covered retiree plan-related prescription drug costs" in the Subpart R preamble to the final rule at 70 FR 4403 and a discussion paper titled "Medicare Part B Versus Part D Coverage Issues" which can be found on the CMS Website. Conversely, in calculating the value of defined standard prescription drug coverage under Part D, all Part D drugs are considered, including those that the sponsor's plan does not cover.

Eligibility for Medicare Supplemental Adjustment

In §423.884(d)(5)(iii)(B)(2), for purposes of the net value prong of the actuarial equivalence test, the value of the defined standard prescription drug coverage under Part D can be adjusted to reflect the impact of a sponsor's plan supplementing Part D for those beneficiaries in the sponsor's plan who enroll in Part D. This guidance clarifies that the adjustment can only be made by those sponsors who actually supplement the Part D coverage of the Medicare-eligible beneficiaries in their plan who enroll in Part D. A sponsor has flexibility in providing such supplemental coverage. For example, it can design its retiree drug plan to be secondary to any Part D plan selected by a retiree, or it can designate specific Part D arrangements under which the supplemental coverage is provided (including through customized Part D arrangements providing enhanced coverage pursuant to a waiver for the sponsor's retiree coverage). The attestation must take into account any restrictions in beneficiary accessibility to the supplemental coverage by prorating for the share of retirees who have access to the supplemental coverage in determining the impact on the Medicare Supplemental Adjustment value.

The final rule does not require that sponsors supplement Part D coverage for their retirees who enroll in a Part D plan. However, they cannot take into account the Medicare Supplemental Adjustment value pursuant to §423.884(d)(5)(iii)(B)(2) if they do not supplement Part D for a retiree who enrolls in Part D.

Sponsors interested in the Medicare Supplemental Adjustment but concerned about the ability to coordinate their benefits with Part D coverage should be aware that CMS is facilitating the establishment of a coordination of benefits system that will provide, by January 1, 2006, real time, point-of-sale coordination between Medicare Part D and supplemental plans such as employer and union-sponsored plans. Such a system should provide for cost-effective coordination between Medicare and retiree health plans, including those in which a sponsor is providing the coverage to qualify for the Medicare Supplemental Adjustment.

Benefit Options within a Plan

A benefit option is defined in §423.882 of the final rule as a particular benefit design, category of benefits, or cost-sharing arrangement offered within a group health plan. The final rule in §423.884(d)(5)(iv) provides sponsors with plans with multiple benefit options the flexibility to submit the actuarial equivalence attestation either for each benefit option separately or in the aggregate for options that meet the "gross value" test. That is, each benefit option must separately pass the gross test, but the plan can pass the net test by testing benefit options on an aggregated or separate basis.
This guidance clarifies that the sponsor's attestation can combine either all of the benefit options that meet the gross value test or one or more subsets of those options for purposes of applying the "net value" test and submitting the actuarial attestation. The sponsor (working with its actuary) determines the number of options to be combined for this purpose. If the sponsor combines two or more benefit options, the sponsor may not claim

the subsidy for those benefit options excluded from the net value calculation, even if those options meet the gross test.

In applying the gross value and net value test to each benefit option separately (or in the aggregate to a subset of the options), it will be within the discretion of the attesting actuary, in accordance with actuarial standards, to determine the applicability of plan experience across benefit options. For example, an actuary may determine that aggregate plan experience is not applicable to each benefit option even if these benefit options are being aggregated for testing purposes and instead may apply the plan experience unique to each benefit option. Conversely, an actuary may decide to apply the aggregate plan experience to each individual benefit option if the experience segregated by individual benefit option is non-existent or is an unreliable indication of costs.

Integrated Health and Drug Situations

In the final rule it is indicated that sponsors of plans that charge a single, integrated premium or contribution to their retirees for both medical and drug coverage have the complete discretion and flexibility to allocate any portion of the premium to the drug coverage for the purpose of the net value test of actuarial attestation. See §423.884(d)(5)(ii)(B).

This guidance addresses plans that have integrated cost sharing for medical and prescription benefits. Integrated cost-sharing is based on plan experience (unlike premiums, which is a factor of plan design). Accordingly, for benefit plans where the plan design covers both prescription drugs and other medical costs (for example, integrated out-of-pocket limits, integrated deductibles, integrated plan maximums, etc.), an actuary must be able to reasonably estimate and allocate the cost-sharing provisions and cost of benefits for prescription drugs. This allocation can be based upon either actual plan cost experience or on future cost projections. Once this allocation is made, then the value allocated to the drug coverage must pass the gross value test of the actuarial attestation.

Sample Calculation and Simplified Computations for the Actuarial Equivalence Test

Sample Calculation

To assist actuaries in determining the Medicare Supplemental Adjustment, the appendix to this guidance includes a sample calculation showing the steps for the actuarial equivalence test using the “Medicare Supplemental Adjustment.” The sample calculation for actuarial equivalence testing utilizes standard actuarial techniques for calculating values of deductibles and coinsurance on a probability distribution, which was previously released by CMS. For plans with co-pay cost-sharing structures, similar techniques would need to be utilized. Further explanation on the techniques and parameters is provided in the appendix.

Simplified Calculations

For those plans that pass the two-prong actuarial equivalence test without the Medicare Supplemental Adjustment, there is no requirement to calculate the adjustment for the "net value" test. Furthermore, if the attesting actuary, in his/her professional judgment, is certain that the sponsor's plan is at least actuarially equivalent to Part D without performing the calculation of either the "gross value" test or the "net value" test, then it is within the actuary's professional discretion as to whether the calculations need to be made to support the attestation. For example, if a retiree drug plan that covers both brand and generic drugs, has a $100 deductible, pays 80% of the cost of drugs with the beneficiary paying the remaining 20% as coinsurance, and the sponsor pays 90% of the premium, this plan would clearly be actuarially equivalent to the defined standard prescription drug benefit under Part D and there would be no need to do the specific calculations.

Normative Data Sets

Certain retiree prescription drug plans may not have sufficiently reliable plan data to use to determine whether the plan's coverage is at least actuarially equivalent to the defined standard prescription drug coverage under Part D. It will be within the discretion of the attesting actuary, in accordance with actuarial standards, whether a plan has sufficiently reliable data for the computation. The attesting actuary may find that utilizing an appropriate normative data set is appropriate as indicated in §423.884(d)(5)(ii)(A) and (d)(5)(iii)(A) of the final rule. Possible normative data sets are:

1. The accepted normative data set tools of the industry provided that the data reflect the demographics and other risk characteristics of the group and are appropriately segregated; or
2. The vendor "block of business" data set.

The calculation of actuarial equivalence should rely on plan experience to the extent that the experience is reasonable and credible. If reasonable and credible experience is not available, the calculations should reflect reasonable actuarial methods that take into account the demographics and other risk characteristics of the group.